HealthPAC
Health Program of Alameda County

Alameda County Health Care Services Agency
POLICY AND PROCEDURE

Policy Name	Enrollment and Eligibility
Department Owner	HealthPAC Administrator
Lines of Business	LIHP – MCE / HCCI
Effective Date	6/30/2011

HealthPAC Plan:

Eligibility, Applications, Enrollment, and Services

Signature _____ Date: 6/23/11

Alex Briscoe
Director, Alameda County Health Care Services Agency

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ALAMEDA COUNTY
HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) PLAN

A. POLICY STATEMENT AND PROGRAM OBJECTIVES:

As mandated per Section 17000 of the Welfare and Institutions Code, it is the policy of the County of Alameda to provide comprehensive health care services through a contracted network of health care providers to its medically indigent population. This program is referred to as the Health Program of Alameda County (HealthPAC). Health care services are provided through the HealthPAC Provider Network, which includes the Alameda County Medical Center (ACMC), Alameda County Behavioral Health Care Services community-based organizations.

The Program objectives are to (1) optimize patient health and well-being by focusing on prevention and proactive health management, (2) control health care costs through a variety of means including reductions in the inappropriate utilization of crisis and emergency services, (3) provide an equitable and uniform method of payment for health services, (4) provide consistency in application of eligibility standards, (5) develop a standardized and coordinated demographic and service database and (6) more fully empower patients to take a more active role in their own care.

HealthPAC includes three populations of individuals that must also meet county residency requirements:

1) **HealthPAC Medi-Cal Coverage Expansion (MCE)**
Individuals meeting the criteria of the the Medi-Cal Coverage Expansion (MCE) population, which are individuals between the ages of 19 and 64 who have family incomes at or below 133 percent of the Federal Poverty Level (FPL), are not eligible for Medicaid or CHIP, are not pregnant, and who are a United States citizen or have been a legal permanent resident for at least five years; and

2) **HealthPAC Health Care Coverage Initiative (HCCI)**
Individuals who meet the criteria of the Health Care Coverage Initiative (HCCI) population, which are individuals between the ages of 19 and 64 who have family incomes above 133% FPL through 200% of the FPL, are not eligible for Medicaid or CHIP, are not pregnant, and are a United States citizen or have been a legal permanent resident for at least five years; and

3) **HealthPAC County**
Individuals enrolled in HealthPAC who are not eligible for MCE or HCCI and are between 0 and 200% of the FPL.

HealthPAC MCE is for individuals who will be eligible for Medi-Cal in January 2014 and HealthPAC HCCI is for individuals who will be eligible for the Health Exchange in January 2014 (see eligibility section below). HealthPAC MCE has the added benefit of covering out-of-network emergency services. The scope of services for HealthPAC HCCI and HealthPAC County is the same.

B. PROGRAM MANAGEMENT:

The HealthPAC Plan, under the direction of the Board of Supervisors, is administered by the Alameda County Health Care Services Agency (HCSA). The Alameda Alliance for Health (the Alliance) will serve as the Third Party Administrator (TPA) for the program. Through a contract with HCSA, the Alliance will be responsible for:

- Printing and distributing educational materials to new participants at enrollment.
- Providing customer service.
- Coordinating non-emergency transportation.
- Processing appeals and grievances.
- Sending renewal letters.
- Providing eligibility tapes
- Developing monitoring and performance reports

C. SCOPE OF SERVICES

The **HealthPAC** services are the Medi-Cal Scope of Services as defined in Section 14132 of the Welfare and Institutions Code with the following exceptions to be consistent with the Low Income Health Program developed under the 1115 Medicaid Waiver that passed in November, 2010:

- The "optional" benefits that are offered under Medi-Cal to individuals under 21, are only offered to individuals under 19 in HealthPAC,
- Podiatry is an added benefit
- Hospice and home health care are not covered
- In general, services are only covered if they are provided through the network; HealthPAC MCE participants can get their out-of-network (hospitals within California) covered for emergency services.

See Appendix A, the HealthPAC Division of Financial Responsibility (DOFR) for more information. HealthPAC is always the payor of last resort. HealthPAC uses the ACMC formulary.

D. ELIGIBILITY:

1. TO BE ELIGIBLE FOR HealthPAC COVERAGE INDIVIDUALS MUST:

a. Be a resident of the County of Alameda
i. persons with a valid Visa are not eligible, **and**

b. Have a gross monthly household income level at or below the 200% Federal Poverty Level (FPL) (refer to Appendix, B, Federal Poverty Level Schedule, Appendix C, Guidelines for Determining Family Unit Size, and Appendix D, Using Federal Income Tax Forms for Documenting Income), **and**

c. Not be enrolled in or eligible for full-scope Medi-Cal

d. Enrollment is voluntary.

e. Enrollment discrimination is prohibited.

2. **TO BE ELIGIBLE FOR HealthPAC MCE (0-133% FPL) and HealthPAC HCCI (133 200% FPL) INDIVIDUALS MUST:**

a. Meet the criteria under Section D.1, **and**

b. Be age 19 through 64, **and**

c. Not be eligible for any Medi-Cal Programs or the Access for Infants and Mothers Program, Children's Health Insurance Program **and**

d. Have documentary evidence of United States citizenship (or Legal Residency for five years) and identity (refer to Appendix E HealthPAC Verification Documents and Appendix F Exceptions to Five Year Bar for Legal Residency).

E. APPLICATION:

1. SCREENING FOR THE HealthPAC APPLICATION:

The HealthPAC Provider Network should determine HealthPAC eligibility for the entire family unit using One-e-App, the web-based health enrollment system.

a. All reasonable efforts should be made to initiate HealthPAC applications prior to the clinical appointment in order to ensure HealthPAC coverage.
   i. Eligibility for ***unscheduled*** services, i.e., Emergency Room/Urgent Care should be determined at time of service unless previously enrolled.
   ii. No application assistor or fellow employee of an assistor is to process, complete or access a HealthPAC application in One-e-App for that assistor or their immediate family.
   iii. Assistors are not to get involved in the normal handling of any applications of self, relatives, friends, fellow employees, or acquaintances.

b. In some cases, HealthPAC applications will be started at a specialty mental health services site. The initial screening will be conducted by the provider and data will be transferred to One-e-App.

c. During the application process, the applicant will be asked to choose a medical home. If an applicant does not choose a medical home, the applicant will be contacted by the Alameda Alliance for Health. If the applicant still does not choose a medical home, they will be assigned a medical home based on factors that may include geographic proximity, demographic and language factor. It is the responsibility of the medical home clinic to ensure clients have access to care. If the clinic is at capacity and cannot see any more clients, the clinic must immediately report to HealthPAC Customer Service that they are full and not taking new patients. Participants can choose to change their medical home by through a clinic location or by calling HealthPAC customer service.

d. As part of the application process the application assistor will inform applicants of their right to file an internal grievance or appeal.

e. One-e-App assigns the applicant to the correct program based on income and ability to meet DRA requirements.

f. Applications are audited and approved or denied by County staff. If an application is missing verification documentation, it may be returned to the application assistor. The application assistor has 28 calendar days to complete and return the application to the auditor. If the application is not completed, it will be denied and a notification letter will be sent to the applicant.

2. APPEAL PROCESS FOR DENIED APPLICATIONS

a. Applicants may appeal the decision of denial in **HealthPAC** by contacting HealthPAC Customer Service. HealthPAC Customer Service will acknowledge the receipt of the appeal in writing. Written notice of the resolution of the appeal will be provided within sixty (60) days of receipt of the appeal (see Appendix G: HealthPAC Appeal and Grievance Process).

F. ENROLLMENT:

1. ENROLLMENT PERIOD

Enrollment period for HealthPAC will be for a one-year period.

The enrollment period starts on the first day of the month in which the application was started.

2. DOCUMENTATION REQUIREMENTS:

a. Enrollment in **HealthPAC** requires documentation to prove identity, income, and Alameda County residency (see Appendix E, HealthPAC Verification Documents, Appendix F, Exceptions to Five Year Bar for Legal Residency, and Appendix H, HealthPAC Statement of Income and Residency).

b. Enrollment in HealthPAC MCE and HealthPAC HCCI requires documentation to prove identity, income, Alameda County residency, age, and United States citizenship (or Legal Residency for five years) (see Appendix E, HealthPAC Verification Documents, Appendix F, Exceptions to the Five Year Bar for Legal Residency, and Appendix H, HealthPAC Statement of Income and Residency).

3. RETROACTIVE ENROLLMENT:

a. There is no retroactive eligibility for **HealthPAC**.

4. SERVING PARTICIPANTS

a. HealthPAC eligibility determined **for any participant** by **any** provider within the HealthPAC **outpatient** provider network shall be honored by all providers within the HealthPAC **outpatient** provider network for the duration of the eligibility determination period providing there has been no change of circumstance impacting eligibility.

b. All new HealthPAC participants will receive an identification card indicating membership and a designated medical home chosen by the participant. Primary care services will provided by the medical home provider. Specialty, emergency room, and inpatient services will be provided through the Alameda County Medical Center at the Highland Campus.

c. A medical home provides:

i. Enrollment (renewal) assistance in HealthPAC
ii. A primary health care contact who facilitates the participant's access to preventive, primary, specialty, mental health, or chronic illness treatment, as appropriate.
iii. An intake assessment of each new participant's general health status.
iv. Referrals to qualified professionals, community resources, or other agencies as needed.
v. Care coordination for the beneficiary across the service delivery system, as agreed to between the medical home and the County. This may include facilitating communication among participant's health care providers, including appropriate outreach to mental health providers.
vi. Care management, case management, and transitions among levels of care, if needed and as agreed to between the medical home and the County.
vii. Use of clinical guidelines and other evidence-based medicine when applicable for treatment of the participant's health care issues and timing of clinical preventive services.
viii. Focus on continuous improvement in quality of care.
ix. Timely access to qualified health care interpretation as needed and as appropriate for participants with limited English proficiency, as determined by applicable federal guidelines.
x. Health information, education, and support to beneficiaries and, where appropriate, their families, if and when needed, in a culturally competent manner.

d. Primary Care and related pharmacy, radiology and laboratory is provided by the patients medical home. All specialty, inpatient, and emergency services (and related pharmacy, radiology, and laboratory) are provided by the Alameda County Medical Center, Highland hospital. Specialty mental health services are provided through Alameda County Behavioral Health Care Services (BHCS) or a contractor of BHCS. Once a patient is stabilized (either by County specialty mental health or ACMC), and sent back to primary care, the care and related pharmacy is the responsibility of the medical home. If Highland hospital does not provide a covered specialty or inpatient service, ACMC

will contract out to another provider. MCE participants are covered for emergency services provided at hospitals in California other than Highland Hospital.

e. Enrollees have a choice of medical home, Primary Care Physician, and health care provider.

5. DISENROLLMENT:

a. A person may be disenrolled from **HealthPAC** for the following reasons:

i. He/she no longer meets the Federal Poverty Level requirement (disenrolled back to date of circumstance change),
ii. He/she no longer meets the Alameda County residency requirement (disenrolled back to date of circumstance change) ,
iii. He/she provided false information at the time of enrollment (disenrolled back to first day of enrollment period),
iv. He/she did not comply with other payor application process. Specifically, for those individuals who were determined preliminarily eligible in One-e-App for Medi-Cal or Healthy Families but did not complete the application process, withdrew from the application process, or **were** denied due to failure to comply with the application process (disenrolled back to first day of enrollment period),
v. He/she is incarcerated (disenrolled back to day of incarceration),
vi. He/she is institutionalized in IMD (disenrolled back to day institutionalized),
vii. He/she requests disenrollment (disenrolled back to the requested date),
viii. He/she turns 65 (disenrolled as of 65th birthday).

b. Disenrollment discrimination is prohibited.

G. FINANCIAL LIABILITY:

1. HealthPAC eligible participants may be responsible for a co-payment (refer to Appendix I, HealthPAC Liability Schedule).

a. No enrollment fees or premiums are allowed.
b. The total cost for a family in a year can NOT exceed 5 percent of the family's income.

2. HealthPAC eligible persons who have a referral from the Public Health Department that requires a mandated Public Health Service shall have their HealthPAC co-payment waived. This includes assessment, evaluation, and treatment for: outpatient Tuberculosis (TB), sexually transmitted diseases (STDs), immunizations, vaccine preventable diseases, enteric infections and other acute communicable disease related medical services for cases and suspected cases and contacts.

H. AUDIT PROTOCOL:

HealthPAC audits will be conducted remotely via the ACHCSA centralized database (One-e-App). Audits will be comprehensive and will include, but not be limited to the following:

1. Review of verifications of identification, residency, income and, U.S. Citizenship/Naturalization to ensure that appropriate verifications were obtained and retained.
2. Review of appropriate use of the HealthPAC Statement of Income.
3. Review of current Full Scope Medi-Cal coverage or non-compliance with Medi-Cal enrollment.
4. Review of appropriate "opt-outs" or suspension of preliminary Medi-Cal determination.
5. Review of consent signatures

I. QUALITY MEASUREMENT AND IMPROVEMENT:

Health Care Services Agency will objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to participants of HealthPAC (see Appendix J, HealthPAC Quality Measurement and Improvement Plan).

Appendix A

HealthPAC
Health Program of Alameda County

Division of Financial Responsibility – DOFR

6.19.11

Key:
CBO= Community Based Organization
ACMC= Alameda County Medical Center
PCP= Primary Care Provider
County= HCSA and/or one of its departments
"x"= indicates this group is financially responsible for the provision of the designated service
NA= Not Applicable

NOTE: All out-of-network emergency services apply only to the Medi-Cal Expansion (MCE) population						
HEALTH CARE SERVICE	**CBO + ACMC PCP Clinics**	**ACMC Hospitals/ Specialty**	**County**	**Referral to ACMC**	**Authorization Required**	**COMMENTS**
ABORTION / PREGNANCY SERVICES / FAMILY PLANNING	NA	NA		N	N	Limited to Family PACT (California Family Planning, Access, Care, and Treatment).
ACUPUNCTURE	x			N	N	Limited to age < 19
ALLERGY IMMUNOTHERAPY		x		Y	N	
ALLERGY TESTING,TREATMENT AND SERUM		x		Y	N	
AMBULANCE - EMERGENCY • In Area • Out of Area			x NA	N	N	
Ambulance- Inter-hospital, non-emergency, specific to out-of-network inpatient adminissions (Medi-Cal Expansion only)		x		Y	Y	Authorization done by Alliance
ANESTHESIOLOGY (related to surgery)		x		N	N	
AUDIOLOGY SERVICES (including Hearing Aids, repairs, maintenance, and surgically implanted)		x		Y	N	Limited to age < 19
BLOOD/BLOOD PRODUCTS • Blood Bank • Autologous/Homologous • Storage and Collection of Blood		x x x		Y	N	
CARDIAC REHABILITATION -When associated with Inpatient, • Technical Component • Professional Component		x x		Y	N	

NA – Non-covered service.

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
CARDIAC REHABILITATION – If in MD office or referred by MD office, except when associated with IP stay • Technical Component • Professional Component		 X X		Y	N	
CCS				N/A	N/A	Carve out to CCS
CHEMICAL DEPENDENCY / SUBSTANCE ABUSE	X		X	N	Y	Limited to authorized services for individuals with co-occurring mental health conditions. BHCS needs to authorize that client meets specialty mental health eligibility criteria.
CHEMOTHERAPY • Drugs, including Epogen, Neupogen and adjunctive therapies • Facility Component • Professional Component		X X X		N	N	
CHIROPRACTIC	X			N	N	Limited to age < 19
COSMETIC SURGERY (Medically Necessary) • Facility Component • Professional Component		X X		Y	N	
CRITICAL CARE VISITS • Facility • Professional		X X		N/A	N/A	
DENTAL SERVICES – EMERGENCY ADULT • Facility Component • Professional Component	X X	X X		N	N	Age (Adult) ≥ 19. Same definition as Medi-Cal.
DENTAL SERVICES CHILD <19 • Facility Component • Professional Component	X X	X X		N	N	Age Limit < 19
DIAGNOSTIC TESTING IN OFFICE (EKG, X-RAY)	X			N	N	
DIAGNOSTIC TESTING (Including but not limited to CT Scans, PET Scans, MRIs, hearing tests, colonoscopies, EEG etc.) • Facility Component • Professional Component		 X X		Y	N	When associated with IP stay, Ambulatory or OP Surgery and ER; includes outside facility during an IP stay.
DURABLE MEDICAL EQUIPMENT • Outpatient • Surgically Implanted		 X X		Y	Y	Authorization by Alliance
EMERGENCY ADMISSIONS – Highland Hospital • Facility Component • Professional Component		 X X		N	N	ACMC

NA – Non-covered service.

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
EMERGENCY ADMISSIONS pre-stabilization– Out-of-Area (Medi-Cal expansion only) • Facility Component • Professional Component		 X X		N	N	Within California. Notification must be done w/in 24 hours.
EMERGENCY ADMISSIONS post stabilization – Out-of-Area (Medi-Cal expansion only) • Facility Component • Professional Component		 X X		Y	Y	Within California. Notification must be done w/in 24 hours.
EMERGENCY ROOM VISITS – Highland Hospital • Facility Component • Professional Component		 X X		N	N	ACMC
EMERGENCY ROOM VISITS – pre-stabilization– Out-of- Area (Medi-Cal expansion only) • Facility Component • Professional Component		 X X		N	N	Within California. Must notify within 24 hours.
EMERGENCY ROOM VISITS – post-stabilization– Out-of- Area (Medi-Cal expansion only) • Facility Component • Professional Component		 X X		Y	Y	Within California. Must notify within 24 hours.
EXTENDED CARE/SKILLED NURSING FACILITY • Facility Component • Professional Component		 X X		Y	Y	ACMC authorization
HEMODIALYSIS • Facility Component • Dialysis Drugs • Professional Component		 X X X		Y	N	
HOSPITAL BASED PHYSICIANS – pre-stabilization-OUT OF AREA – (Medi-Cal Expansion only) – Emergency Admit • Professional Component • Emergency Room Staff MD (99281-99299 only)		 X X		N	N	Inpatient and ER Admissions. Within California. Must notify within 24 hours.
HOSPITAL BASED PHYSICIANS – post-stabilization OUT OF AREA – (Medi-Cal Expansion only) – Emergency Admit • Professional Component Emergency Room Staff MD (99281-99299 only)		 X X		N	Y	Inpatient and ER Admissions. Within California. Must notify within 24 hours.
IMMUNIZATIONS – Standard Adult and Pediatric— NOT TRAVEL related and NOT work related.	X			N	N	
INCONTINENCE CREAMS / WASHES	X	X		Y	N	Limited to Age < 19
INJECTIBLES		X		Y	N	
LABORATORY SERVICES • Office • Reference lab (per defined CPT code)	X	X X		N Y	Y	Authorization for reference lab done by ACMC

NA – Non-covered service.

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
LITHOTRIPSY • Facility Component • Professional Component		 x x		Y	N	
MEDICAL SUPPLIES	x	x		Y	N	
MENTAL HEALTH – John George/Inpatient and ER • Facility Component • Professional Component		 x x			Y	No authorization required for ER. Services covered under separate contract b/w BHCS and ACMC.
MENTAL HEALTH-ER/ Inpatient- Out of Area (Medi-Cal expansion only) • **Facility Component** • **Professional Component**			 x x	N	Y	Auth completed by BHCS. For psychiatric emergency and forensic.
MENTAL HEALTH – Outpatient • Facility Component • Professional Component	 X x		 X x	N	Y	Auth Completed by BHCS (for specialty mental health only)
OFFICE VISITS- Primary Care	X			N	N	
PATHOLOGY- When associated with IP, Ambulatory Surgery or Emergency Room • Professional Component • Technical Component		 x x		N	N	Except PAP smears
PATHOLOGY – In MD office or when referred by MD office, except when associated with, IP stay, OP/Ambulatory Surgery or ER, as noted above) • Technical Component • Professional Component		 x x		N	N	
PHARMACY SERVICES	x	x		N/A	N	ACMC has an approved formulary.
PODIATRY	x	x		Y	N	Referral required for hospital based service only.
PROSTHETIC/ORTHOTIC DEVICES • Outpatient • Surgically Implanted		 x x		Y	N	
PSYCHOLOGY SERVICES	x	x	x		Y (for County provided services)	Medi-Cal exclusion allows services at FQHC. County provides services for SMI population.

NA – Non-covered service.

HEALTH CARE SERVICE	CBO + ACMC PCP Clinics	ACMC Hospitals/ Specialty	County	Referral to ACMC	Authorization Required	COMMENTS
RADIATION THERAPY		x		Y	Y	Authorization by ACMC
Specialty Care Office Procedures		x		Y	N	
Specialty Care Office Visits		x		Y	N	
Specialty Procedures • Diagnostic • Therapeutic		 X x		Y	Y	Authorization by ACMC
SURGERY - Inpatient • Facility Component • Professional Component		 x x		Y	N	
SURGERY – Outpatient • Facility Component • Professional Component		 x x		Y	N	
THERAPY: Physical • Inpatient • Outpatient/Office		 x x		Y	Y	
TRANSPLANTS Facility Component • Organ Procurement • Covered Immunosuppressive • Professional Component	NA	NA		N/A	N	Not a covered benefit
TRANSPORTATION, NON EMERGENCY MEDICAL			x		Y	Authorization done by Alliance.
VISION CARE	x	x		Y	N	Does not include eyeglasses or other eye applicances.

NA – Non-covered service.

Health – PAC NON-COVERED SERVICES	
	COMMENTS
NON-COVERED SERVICES • Acupuncture Age ≥ 19 • Adult Day Health Care • Alopecia treatment • Artificial Insemination, Infertility Services and Conception by artificial means • Audiology Age ≥ 19 • Bariatric Surgery • Biofeedback • Chemical dependency services (without co-occurring mental health condition) • Dental (only emergency dental covered for Age ≥ 19) • Chiropractic Age ≥ 19 • Custodial Care • Cosmetic Services - to change the way you look, not medically necessary • Exercise and hygiene equipment • Home health • Hospice Care • Incontinence Supplies Age ≥ 19 • Infertility Testing and Treatment... Refer to Family PACT • Inpatient Convenience items • Maternity - deliveries • Organ Transplants • Private Rooms • Reversal of Sterilization • Services provided as a requirement of employment, licensing or court order • Speech and hearing exams • Travel & lodging expenses • Therapy- occupational, respiratory and speech. Speech is covered for under 19. • Vision care - for Adults ≥ 19 services only include procedures for evaluation of visual system. Does NOT include eyeglasses or other eye appliances. • Services provided outside of the US	**NON-COVERED MEDICAL SERVICES**

NA – Non-covered service.

Appendix B: Federal Poverty Level Schedule

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
FEDERAL POVERTY LEVEL
EFFECTIVE APRIL 1, 2010

% OF POVERTY LEVEL	***MAXIMUM GROSS MONTHLY INCOME PER FAMILY SIZE***										
	1	2	3	4	5	6	7	8	9	10	FOR EACH ADD'L MEMBER ADD:
0 - 133%	1207	1630	2054	2477	2901	3324	3747	4171	4594	5017	423
133 - 150%	1361	1839	2316	2794	3271	3749	4226	4704	5181	5659	478
150 - 200%	1815	2452	3088	3725	4362	4998	5635	6272	6908	7545	637
Over 200%	PATIENTS WHOSE GROSS MONTHLY INCOME IS OVER 200% OF THE FEDERAL POVERTY INCOME GUIDELINES SHALL BE CONSIDERED PRIVATE PAY.										

APPENDIX C: GUIDELINES FOR DETERMINING FAMILY SIZE

FAMILY UNIT:

A family unit is comprised of:

1) a single adult with or without children,
2) a married couple with or without children, or
3) an unmarried couple with common children.

Note: If there is more than one family unit living in the household—parents of adults, grandparents, uncles/aunts/cousins, etc.--each family would be ***considered a separate Family Unit.)***

Exception: Other family members may be counted in the family unit if they are declared as a dependent for IRS. In such cases, evidence of dependency must be provided.

FAMILY INCOME:

Family income includes income from all family members including public funds, i.e., SSI, Cal-Works, etc.

- **Student loans, grants and scholarships are exempt from income.**
- **Care expenses are not deducted from gross income. This includes, but is not limited to alimony, child support, or elderly support.**

Table 1 provides scenarios for determining family unit and family income in order to help determine CMSP/ACE eligibility.

IN DETERMINING HealthPAC ELIGIBILITY, ELIGIBILITY OF ANY MEMBER IN THE FAMILY INTO OTHER HEALTH COVERAGE PROGRAMS, I.E., MEDI-CAL, HEALTHY FAMILIES, ETC. NEEDS TO BE PURSUED PRIOR TO ENROLLMENT INTO THE CMSP PROGRAM.

Table 1

SCENARIO	FAMILY UNIT	INCOME CONSIDERED (Refer to CMSP Liability Schedule to determine CMSP eligibility)
1. *Single working male/female*	*One*	*Total gross income*
2. *Married working couple w/no children*	*Two*	*Total gross income*
3. *Married working couple with four children under age 21 living in household.*	*Six*	*Total gross income*
4. *Married couple whose elderly parents live with them but parents have no income*	*Two separate family units* • *Married couple = 2* • *Elderly parents = 2*	• *Married couple's gross income.* • *Elderly parents, aid in kind from adult children*
5. *Foster parents receiving foster care allocation for foster children.*	*Two (foster parents)*	*Income of foster parents only. (Foster care allocation is not considered when determining gross monthly income.)*
6. *Grandparents taking care of grandchildren who are on CalWorks.*	*Two (grandparents)*	*Income of grandparents only. (CalWorks income for grandchildren is not considered when determining gross monthly income)*
7. *Married couple, husband receives SSI; wife needs health care and only income is husband's SSI.*	*Two*	*Husband's income from SSI.*
8. *Unmarried couple with no children.* • *Male is working, female is not working and has no health coverage.* • *Female presents for health care*	*One* • *Male=1* • *Female=1*	*Complete CMSP Statement of Income and Residency*
9. *Unmarried couple with two (2) **common children** and two (2) children from other marriages/relationships.* • *Male works, female does not work, no health coverage.* • *Male or female or **common child** presents for health care*	*Six*	*Income from male*

Using Federal Income Tax Forms to Document Income for the HealthPAC Program

Using federal income tax forms documents the income only for those family members in the household whose income is reported on that form. Other family members whose incomes are counted and not listed (e.g., spouses filing separately, children who receive child support, Social Security, etc.) must provide separate proof of income.

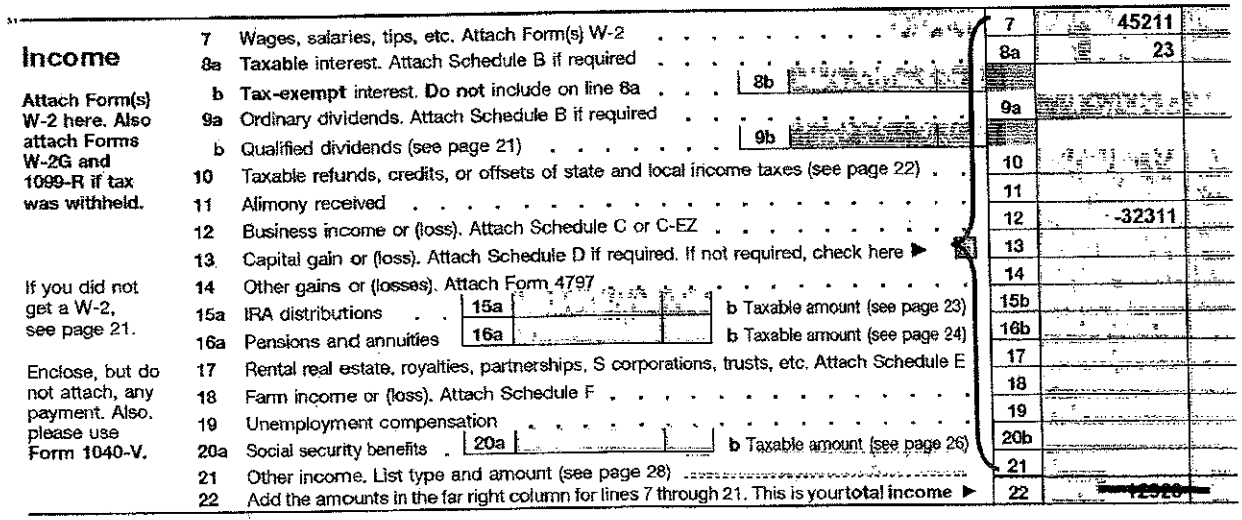
Using the federal income tax form for the year prior to the previous year will only be accepted until the April 15th tax filing deadline. For example, if a family applied in February 2009, the 2007 federal tax forms could have been used to verify the family's income. After April 15th of each year, applicants can only use their federal tax forms for the previous year. If applicants submit federal tax forms from a period other than the previous year, the tax forms will be considered too old and will not be accepted as proof of income. Applicants will be required to submit their previous year's federal tax forms or some other form of documentation to prove their income. Instructions for using specific federal tax forms are listed below.

Form 1040 U.S. Individual Income Tax Form

Add together all of the positive amounts listed in the "Income Section" (Lines 7 through 21). If applicants have reported losses (negative amounts) on any of the lines of this section, these amounts are counted as zero (see example #1 below – line 12 should be counted as zero.)

So in the example below, the total income should be 45211 + 23 +0 = 45,234

Remember: DO NOT subtract any losses from the positive gross income amount. This amount may be different. DO NOT use the amount on Line 22.

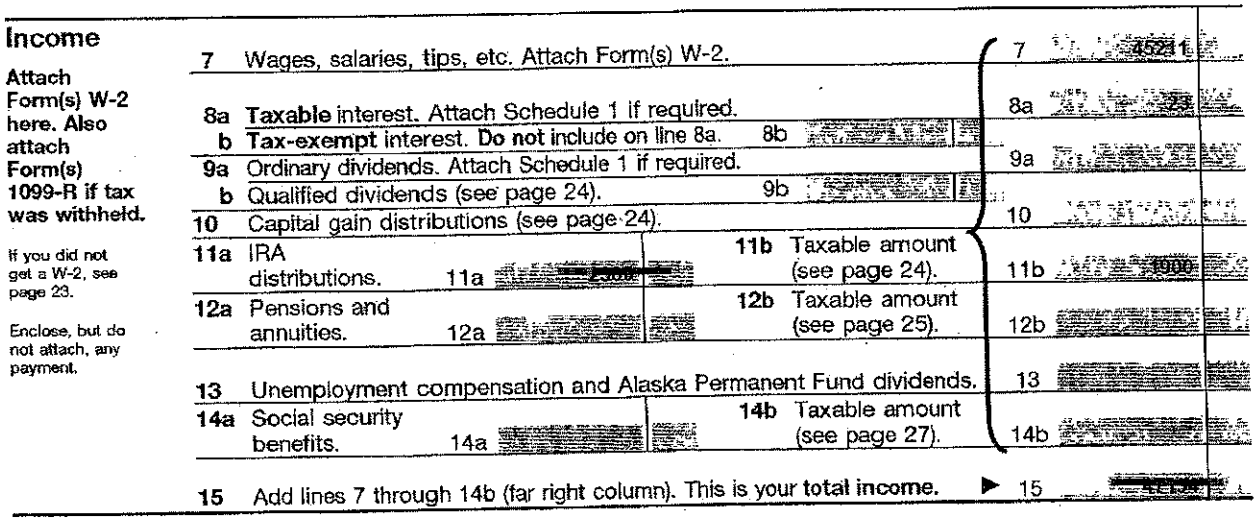


Income				
Attach Form(s) W-2 here. Also attach Forms W-2G and 1099-R if tax was withheld.	7	Wages, salaries, tips, etc. Attach Form(s) W-2	7	45211
	8a	Taxable interest. Attach Schedule B if required	8a	23
	b	Tax-exempt interest. Do not include on line 8a (8b)		
	9a	Ordinary dividends. Attach Schedule B if required	9a	
	b	Qualified dividends (see page 21) (9b)		
	10	Taxable refunds, credits, or offsets of state and local income taxes (see page 22)	10	
	11	Alimony received	11	
	12	Business income or (loss). Attach Schedule C or C-EZ	12	-32311
	13	Capital gain or (loss). Attach Schedule D if required. If not required, check here ▶	13	
If you did not get a W-2, see page 21.	14	Other gains or (losses). Attach Form 4797	14	
	15a	IRA distributions (15a) b Taxable amount (see page 23)	15b	
	16a	Pensions and annuities (16a) b Taxable amount (see page 24)	16b	
Enclose, but do not attach, any payment. Also, please use Form 1040-V.	17	Rental real estate, royalties, partnerships, S corporations, trusts, etc. Attach Schedule E	17	
	18	Farm income or (loss). Attach Schedule F	18	
	19	Unemployment compensation	19	
	20a	Social security benefits (20a) b Taxable amount (see page 26)	20b	
	21	Other income. List type and amount (see page 28)	21	
	22	Add the amounts in the far right column for lines 7 through 21. This is your total income ▶	22	45234

Form 1040A U.S. Individual Income Tax Form

Add together all the positive amounts listed in the "Income Section" (Lines 7 through 14b). This may be different than the amount listed on line 15.

So in the example below, the total income should be 45211 + 23 + 1900 = 47,134

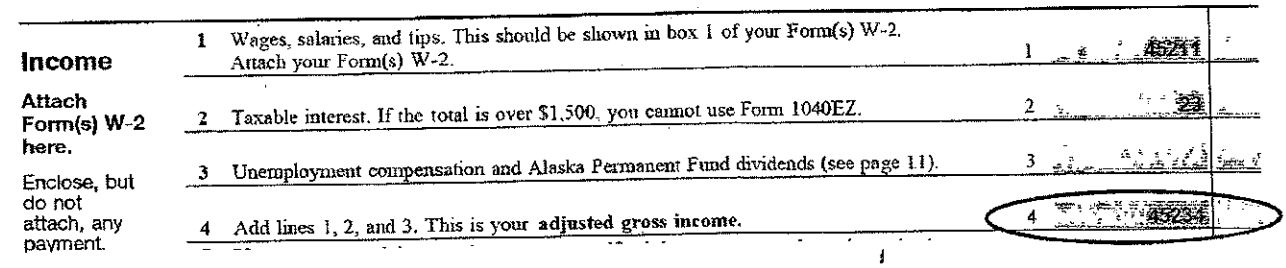


Income					
Attach Form(s) W-2 here. Also attach Form(s) 1099-R if tax was withheld.	7	Wages, salaries, tips, etc. Attach Form(s) W-2.		7	45211
If you did not get a W-2, see page 23.	8a	**Taxable** interest. Attach Schedule 1 if required.		8a	23
Enclose, but do not attach, any payment.	b	**Tax-exempt** interest. **Do not** include on line 8a.	8b		
	9a	Ordinary dividends. Attach Schedule 1 if required.		9a	
	b	Qualified dividends (see page 24).	9b		
	10	Capital gain distributions (see page 24).		10	
	11a	IRA distributions. 11a	**11b** Taxable amount (see page 24).	11b	1900
	12a	Pensions and annuities. 12a	**12b** Taxable amount (see page 25).	12b	
	13	Unemployment compensation and Alaska Permanent Fund dividends.		13	
	14a	Social security benefits. 14a	**14b** Taxable amount (see page 27).	14b	
	15	Add lines 7 through 14b (far right column). This is your **total income.** ▶		15	47134

Form 1040EZ U.S. Individual Income Tax Form

Use Line 4 (Lines 1 through 3) as gross income.

So in the example below, the total income should be 45,234



Income				
Attach Form(s) W-2 here.	1	Wages, salaries, and tips. This should be shown in box 1 of your Form(s) W-2. Attach your Form(s) W-2.	1	45211
Enclose, but do not attach, any payment.	2	Taxable interest. If the total is over $1,500, you cannot use Form 1040EZ.	2	23
	3	Unemployment compensation and Alaska Permanent Fund dividends (see page 11).	3	
	4	Add lines 1, 2, and 3. This is your **adjusted gross income.**	4	45234

ACCEPTABLE CITIZENSHIP (for MCE and HCCI only) AND IDENTITY DOCUMENTS

- *U.S Passport issued without limitation (expired ones are acceptable)*
- *Certificate of U.S Naturalization (N-550 or N-570)*
- *Certificate of U.S Citizenship (N-560 or N-561)*

CITIZENSHIP or Legal Residency for Five years[1] (FOR MCE and HCCI ONLY) *(Column 1)*	***IDENTIFICATION*** *(Column 2)*	**ALAMEDA COUNTY RESIDENCY** (Column 3)	**INCOME** (Column 4)
➢ *If you do not have one of the documents above, provide one citizenship document from this column AND one starred identity document from the next column.*	➢ ***IDENTIFICATION THAT HAS A PICTURE OF THE PERSON IS PREFERRED***	♦ **POSITIVE IDENTIFICATION AS A COUNTY OF ALAMEDA RESIDENT**	
U.S Birth Certificate[1]	***PRIMARY ACCEPTABLE DOCUMENTATION (WITH PHOTO ID):*** ♦ *A recent and valid California or out of state motor vehicle driver's license***	➢ A current and valid California motor vehicle driver's license or Identification Card	➢ Paycheck stubs (Most recent, preferably one month)
➢ *Certification of Report of Birth (DS-1350)*	➢ *Identification Card issued by the Department of Motor Vehicles*	➢ A current and valid California motor vehicle registration in applicant's/family's name	➢ Award letter or checks showing amount of pension or benefits, including social Security and VA
➢ *State Department of Certification of Birth (FS-545 or DS-1350)*	➢ *Voter's Registration Card from other country which has picture, name and birth date*	➢ A recent County of Alameda rent or mortgage receipt or utility bill	➢ Statement from providers of other income (contributions, refunds, child support, etc.)
➢ *U.S Citizen Identification Card (I-197 or I-179)*	➢ *Check cashing card with photo*	➢ Evidence that applicant is receiving General Assistance in County of Alameda County	➢ State Unemployment of Disability award letter/application
➢ *American Indian Card (I-872)*	➢ *School Identification Card with a photo***	➢ Utility Bill of relative/Friend with whom living	➢ Self-employment information: Last year's tax return or current ledgers, current inventory, including business equipment and supplies
➢ *Northern Mariana Card (I-873)*	➢ *A U.S Passport (issued with limitation)***	➢ Other Written Documentation (Specify) (Includes but not limited to the following)	➢ Unemployment check stubs (Most recent, preferably one month)
➢ *Final adoption decree showing a U.S. place of birth*	➢ *Work Badge, Building Pass*	➢ Voter Registration Card (Current)	➢ Worker's Compensation check stubs (Most recent, preferably one month)
➢ *Proof of employment by the U.S. civil service before June 1, 1976*	➢ *Matricula*	➢ Sworn statement from Relative/Friend	➢ Retirement check stubs (Most recent, preferably one month)/Direct Deposit Statement
➢ *U.S. military service record that shows a U.S place of birth*	➢ *Tribal Enrollment Card w/ Photo ID*	➢ School Registration	➢ Income tax documentation from prior calendar year
➢ *U.S hospital record established at the time of the person's birth**	➢ *Border Crossing Card w/Photo*	➢ Bank Account Statement w/Home Address	➢ Other Income – *Interest from* Savings account statements/annuity etc. statements (For persons with no income other than from savings accounts, annuities, etc)
➢ *Life, health, or other insurance card**	➢ *Work Permit w/Photo*	➢ Paycheck Stub w/ Home Address	➢ HealthPAC Statement of Income and Residency
➢ *Federal or State census record that shows the applicant's age and U.S. citizenship or place of birth**	➢ *U.S. Military I.D card or draft record***	➢ Student Loan Grant Award Letter or loan grant papers with home address	➢ Other Written documentation (Specify) ➢ CalWIN Printout for GA and CalWORKS recipients only ➢ Letter from Employer ➢ Aid in Kind
➢ *Seneca Indian tribal census record**	➢ *Federal, state, or local government I.D. card with same identifying information as a driver's license***	➢ CalWIN Printout for Alameda County Residency	
➢ *Bureau of Indian Affairs tribal census record of the Navajo Indians**	➢ *U.S Military dependent identification card***	➢ HealthPAC Statement of Income and Residency	
➢ *U.S. State Vital Statistics birth registration notification**	➢ *Certificate of Degree of Indian Blood or other U.S American Indian/Alaska Native Tribal***	**ALAMEDA COUNTY RESIDENCY AND INCOME**	
➢ *An amended U.S. public birth record (amended more than 5 years after the person's birth)**	➢ *U.S Coast Guard Merchant Mariner Card***	➢ Award letter or checks with home address showing amount of pension or benefits including Social Security and VA	
➢ *Statement of signed by doctor or midwife present at the time of birth**	***SECONDARY ACCEPTABLE DOCUMENTATION (for HealthPAC County only):*** *(Secondary documentation is required if ID does not have a photo)*	➢ GA Referral Form	

[1] Birth Certificates can be obtained either through a State Department or through www.VitalChek.com, a service that provides assistance to electronic orders for vital records for all 50 States. If the applicant has a Social Security Number and/or was born in California you may be able to collect information that will allow ACHCSA make an acceptable birth record match with State/federal records. In order to be eligible for MCE or HCCI a person must have documentary evidence of United States citizenship (or Legal Residency for five years, also see Appendix E Exceptions to Five Year Bar for Legal Residency).

CITIZENSHIP or Legal Residency for Five years (FOR MCE and HCCI ONLY) (Column 1)	*IDENTIFICATION* (Column 2)	ALAMEDA COUNTY RESIDENCY (Column 3)
➢ *Admission papers from a nursing or skilled care facility, or other institution that shows a U.S. place of birth*	➢ *Birth Certificate*	➢ Unemployment check stub with home address (Most recent, preferably one month)
➢ *Medical record (not an immunization record)**	➢ *Church membership or baptism/confirmation record*	➢ Disability check stubs with home address (Most recent, preferably one month)
➢ *I-551 Card (Lawful Permanent Resident/Resident Alien Card) with date indicating 5 years of residency.*	➢ *Tribal Enrollment Card without Photo ID*	➢ Worker's Compensation check stubs with home address (Most recent, preferably one month)
	➢ *Other Written Documentation (Specify)*	➢ Retirement Check stub with home address (Most recent, preferably one month)/Direct Deposit Statement
	➢ *In rare cases the Statement of Income and Residency will be accepted.*	➢ Income tax documentation from prior calendar year with current home address
** Must be dated at least 5 years before your 1st MCE & HCCI application and show a U.S. place of birth*		➢ SSI Check with home address ➢ Notice of Action with Home Address

INSTRUCTIONS FOR NEEDED DOCUMENTATION

Enrollment in **HealthPAC MCE & HCCI** requires documentation to prove:

- Citizenship/ 5-years Legal Residency,
- identity,
- Alameda County residency, and
- income.

- The easiest way for U.S citizens or nationals to provide both proof of citizenship and identity is with one of the documents in the top row "Acceptable Citizen and Identity Documents."
- If the applicant does not have one of those documents they need one citizenship document from the first column and one identity document from the identification column designated with a double star ** (column 2).
- If the person has been born in California you can submit the person's current name (first, middle and last) and name at birth (first, middle and last) date of birth, gender, birth county and mother's maiden name to One-e-App to get a birth record match. A successful match can be used as proof of citizenship.
- Whenever possible, collect the person's full name (both current and at birth), Social Security Number, place of birth, date of birth, and mother's maiden name and ACHCS may be able to make a successful match to confirm citizenship
- You should complete a DHCS 005 form via One-e-App or on paper when citizenship can be verified.
- They also need to prove Alameda County residency and income. They can do this with one Alameda County Residency document from the third column and one income document from the fourth column, or one document from the Alameda County Residency and Income section.
- The HealthPAC Statement of Income and Residency can be used to establish residency and income if all attempts have been made to get other documentation.
- In rare cases, the HealthPAC Statement of Income and Residency can also be used to establish identity.

Enrollment in **HealthPAC County requires** documentation to prove:

1. identity,
2. Alameda County residency, and
3. income.

- HealthPAC County Applicants do NOT need to prove Citizenship.
- Applicants DO need to provide one identity document from the second column and either one Alameda County Residency document from the third column and one income document from the fourth column, or one document from the Alameda County Residency and Income section.
- The HealthPAC Statement of Income and Residency can be used to establish residency and income if all attempts have been made to get other documentation.
- In rare cases, the HealthPAC Statement of Income and Residency can also be used to establish identity for **HealthPAC County** Only.

Appendix F:
Exemptions to Five Year Bar for Legal Residency for HealthPAC MCE and HCCI

Enrollment in HealthPAC MCE and HCCI requires legal residency for five years; however the **following qualified aliens are exempt** from the five-year bar to eligibility:

- Refugees;
- Asylees;
- Cuban and Haitian Entrants;
- Victims of a severe form of trafficking;
- Aliens whose deportation is being withheld;
- Qualified aliens who also are (1) an honorably discharged veteran, (2) on active duty in the U.S. military or (3) the spouse (including a surviving spouse who has not remarried) or unmarried dependent child of an honorably discharged veteran or individual on active duty in the U.S. military;
- Aliens admitted to the country as an Amerasian immigrant;
- Legal permanent residents who first entered the country under another exempt category (i.e. as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or alien whose deportation was being withheld) and who later converted to LPR status.

In addition, the five-year bar to eligibility for HealthPAC MCE and HCCI does not apply to

- Members of a Federally-recognized Indian tribe, as defined in 25 U.S.C. 450b(e); and
- American Indians born in Canada to whom §289 of the Immigration and Nationality Act applies.

Following are the **verification procedures** for determining that an individual is exempt from the five-year bar:

- *Exemptions based on immigration status.* Five of the exemptions from the five-year bar apply to immigrants in a specific immigration status: refugees, asylees, Cuban and Haitian entrants, aliens whose deportation is being withheld and Amerasian immigrants. Immigrants in any of these groups should possess an immigration document establishing their status, which can be verified with the INS in accordance with the procedure generally followed by the state to verify immigration status. Verification of immigration status is discussed in §3212 of the State Medicaid Manual.
- *Exemption based on veteran or active duty status.* Verification of honorable discharge status or active duty requires presentation of an original or notarized copy of the veteran's discharge certificate or current orders showing "Honorable"

discharge from or active duty in the Army, Navy, Air Force, Marine Corps or Coast Guard. Neither discharge "Under Honorable Conditions" nor service in the National Guard satisfies this exemption. States should contact the local Veterans Affairs (VA) regional office if an applicant presents (1) documentation showing honorable discharge from, or active duty in, any other branch of the military; (2) documentation showing any other type of duty (e.g. "active duty for training") or (3) the state has any other reason to question whether or not an applicant satisfies the requirements for this exemption. Verification of veteran or active duty status is discussed in §3212.5 of the State Medicaid Manual. States may also consult Exhibit B to Attachment 6 of the Interim Guidance at 62 Federal Register 61413-61414.

- *Exemption for certain Native Americans.* For purposes of HealthPAC MCE and HCCI eligibility, American Indians born in Canada to whom §289 of the INA applies and members of a Federally-recognized tribe also are exempt from the five-year bar. Some American Indians born in Canada to whom §289 of the INA applies may have documentation establishing legal permanent residence status, which can be verified in accordance with the procedure generally followed by the state to verify immigration status. Alternatively, an applicant claiming to fall under this exemption could present a letter or other tribal document certifying at least 50% Indian blood, as required by §289 of the INA, combined with a birth certificate or other evidence of birth in Canada.

  Applicants can establish membership in a Federally-recognized tribe by presenting a membership card or other tribal document demonstrating membership in an Indian tribe. If the applicant has no documentation, the state can verify membership by contacting the tribe in question.

  Verifying Native American status is discussed in §3212.6 of the State Medicaid Manual as well as in §104.62 and §104.63 of the proposed regulations published by the Department of Justice on August 4, 1998 at 63 Federal Register 41685.

- *Victims of Trafficking.* The Office of Refugee Resettlement (ORR) of the U.S. Department of Health and Human Services has been given authority to certify that an individual is a victim of a severe form of trafficking. ORR issues a letter to all individuals so certified. Thus, to verify an immigrant's status as a victim of a severe form of trafficking, so as to establish an exemption from the five-year bar, the immigrant should present a certification letter from ORR. The letter will contain a certification date, which can be treated as the date of entry for eligibility purposes, as well as an expiration date. Additional information on the eligibility of trafficking victims for benefits can be found in a letter on the Trafficking Victims Protection Act of 2000 from the ORR dated May 3, 2001.

HealthPAC
Health Program of Alameda County

Alameda County Health Care Services Agency
POLICY AND PROCEDURE

Policy Name	Hearings and Appeals
Department Owner	HealthPAC Administrator
Lines of Business	LIHP – MCE / HCCI
Effective Date	6/30/2011

HEARINGS AND APPEAL PROCESS

I. Definitions

A. An "action" is:

1. A denial, termination or reduction of eligibility for Medicaid Coverage Expansion (MCE) or Health Care Coverage Initiative (HCCI).

2. A denial or limited authorization of a requested HealthPAC service, including the type or level of service.

3. A reduction, suspension, or termination of a previously authorized service.

4. A failure to provide HealthPAC services in a timely manner pursuant to the Special Terms and Conditions of the California Bridge to Reform Demonstration for the LIHP.

5. A failure of the HealthPAC to act within the timeframes for grievances and appeals as outlined herein.

B. A "grievance" is an expression of dissatisfaction about any matter other than an action, as "action" is defined above.

C. An "appeal" is defined as a request for review of an action, as defined in A., above.

II. Processes

A. **A process** for internal resolution of HealthPAC applicants and enrollees grievances and appeals of actions; and

B. A process for HealthPAC applicants and enrollees appeal of actions to a State fair hearing.

III. Internal grievance and appeal process and coordination with the State fair hearing process.

A. For those individuals whose HealthPAC eligibility is determined by the State, the State assumes the responsibility and accountability for the resolution process. For those individuals whose HealthPAC eligibility is determined by the county, the State delegates to the county responsibility for the resolution process.

B. Exhaustion of the internal appeal process will be required of a HealthPAC applicant or enrollee prior to filing a request for a State fair hearing to appeal an action. (42 C.F.R. 438.402.)

C. Grievances will not be appealable to a State fair hearing.

IV. Matters outside the scope of the grievance and appeal process, including the right to a State fair hearing.

A. The sole issue is one of Federal or State law or policy, LIHP protocols approved under the Demonstration Standards, Terms and Conditions (STC). (42 C.F.R. 431.230(1).)

B. The establishment of and any adjustments to the upper income limit made by the LIHP, in accord with STC 58(b).

C. The establishment by a LIHP of enrollment caps of HCCI, and if as the result of such cap the HCCI is completely closed, establishment of enrollment caps for MCE. (STC 58(c).)

D. The establishment by a LIHP of wait lists as a result of enrollment caps created in accord with STC 58(c). (STC 58(d).)

E. The requirement that a LIHP make a timely eligibility determination is waived with respect to individuals' eligibility for a capped program while those individuals are placed on a county wait list for that program. The County's determination to place individuals on a wait list, rather than enrolling them in the capped program directly, is not subject to appeal. Nothing in this provision shall preclude those individuals from appealing the County's determination of eligibility for other programs.

V. Grievance and Appeals Process

A. Notice of Grievance and Appeal Rights

1. HealthPAC applicants will be informed of their right to file an internal grievance or appeal and the procedures for exercising this right, as well as the right to appeal an action as identified herein to a State fair hearing upon exhaustion of the internal process. Such information shall be made available in languages in addition to English as outlined in 42 CFR 438.10(c).

2. Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all HealthPAC enrollees at the same time that a Notice of Action is issued (as generally required in B.,(below), and in B.2 and B.3., specifically.

3. Notice of the grievance, appeal and fair hearing procedures and timeframes will be provided to all providers within the HealthPAC network at the time they enter into a contract, or when the HealthPAC begins, whichever is earlier.

B. Notice of Action

1. Format - the notice of action will be in writing, and available in languages in addition to English as outlined in 42 C.F.R 438.10(c).

2. Notice to Applicants – notice will be provided upon completion of an eligibility determination.

3. Timing of Notice for LIHP enrollees – a notice of action will be mailed to HealthPAC enrollees at least 10 calendar days before the date of the action. Exceptions to such notice will follow 42 C.F.R. 431.213.

   a. Notices regarding standard authorization of service that deny or limit services will be provided as expeditiously as the HealthPAC enrollee's health condition requires and within 14 calendar days following receipt of the request for service. (42 C.F.R. 438.210(d)(1).) The timeframe may be extended for up to 14 additional calendar days if the HealthPaC enrollee or provider requests the extension, and the HealthPaC justifies (to the State agency upon request) a need for additional information and how the extension is in the HealthPAC enrollee's interest. Failure to timely reach authorization decisions constitute a denial and an adverse action, and notice must be provided on the date the timeframe expires. (42 C.F.R. 438.404(c)(5).)

   b. When the HealthPAC determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that following the standard timeframe in (a), above, could seriously jeopardize the HealthPAC enrollee's life or health or ability to attain, maintain, or regain maximum function, the HealthPAC must make an expedited authorization decision and provide notice of the authorization decision as expeditiously as the HealthPAC enrollee's health condition requires and no later than 3 working days. The 3 working days time period may be extended by up to 14 calendar days if the HealthPAC enrollee requests an extension or if the HealthPAC justifies (to the State agency upon request) a need for additional information and how the extension is in the HealthPAC enrollee's interest.

   c. The requirement for advance notice may be shortened to 5 calendar days in case of probable fraud by HealthPAC enrollees where the agency has facts indicating probable fraud and those facts have been verified, if possible, through secondary sources. (42 CFR 431.214.)

4. Content of Notice - the intended action; the reasons for the action (including statutory and regulatory references, if applicable); the

effective date of the action; the program requirements that support the action; the HealthPAC enrollee's right to file an appeal; the procedures for exercising these rights; the circumstances under which expedited resolution is available and how to request it, and the circumstances under which benefits are continued and how to request it. (42 CFR 438.404.)

C. The Internal Grievance and Appeal Requirements

1. For both grievances and appeals

   a. The HealthPAC will provide any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY-TTD and interpreter capability (42 C.F.R. 438.406.) for all stages of the grievance and appeal processes, at no cost to applicants or HealthPAC enrollees.

   b. HealthPAC applicants and enrollees must file an internal grievance within 60 calendar days of the incident giving rise to the grievance, and must file an appeal of action within 60 calendar days of the date of the notice of action.

   c. The HealthPAC will acknowledge receipt in writing of each grievance and appeal.

   d. The decision maker must not be involved in any previous level of review or decision making.

   e. The decision maker in the following cases must be a health care professional with the appropriate clinical expertise in treating the HealthPAC enrollee's condition or disease:

      i. An appeal of a denial based on lack of medical necessity.

      ii. A grievance regarding denial of expedited resolution of an appeal.

      iii. Grievance or appeal that involves clinical issues.

2. Requirements for appeals of actions

   a. Oral inquiries seeking to appeal an action will be treated as an appeal and confirmed in writing by the HealthPAC unless the applicant, HealthPAC enrollee or provider requests expedited resolution. The request for expedited resolution may be made orally or in writing.

   b. Applicants, HealthPAC enrollees and their representatives will have the opportunity, before and during the appeals process:

i. To examine the HealthPAC's position statement related to the reason services are delayed, denied or withdrawn by the HealthPAC, the HealthPAC enrollee's case file, including medical records, and any other documents under consideration in the appeal, and

ii. To confront and cross-examine adverse witnesses.

c. HealthPAC applicants and enrollees and their representatives will be provided a reasonable opportunity to present evidence and allegations of fact or law, and cross examine witnesses, in person, in writing, or by telephone if requested by the individual.

d. In regard to the option for HealthPAC applicants and enrollees and their representatives to present evidence via the telephone, hearings can be conducted by telephone or video conference in lieu of an in-person hearing. Such hearings conducted in this manner must meet the following criteria:

i. Telephonic hearings may be requested by the individual, at any stage of the appeals process, free of charge,

ii. The individual must receive a written notice that a hearing can be conducted by telephone or video conference in lieu of an in-person hearing. Such notice must contain information about the process for an individual to review the records, submit evidence, and receive reimbursement for costs in accordance with (3) through (7) of this section C.2.d.

iii. HealthPAC applicants and enrollees and their representatives must have the opportunity, before, and during the appeals process, to examine the HealthPAC's position statement, the HealthPAC enrollee's case file, including medical records, and any other documents under consideration in the appeal.

iv. HealthPAC applicants and enrollees and their representatives must be able to submit evidence and any other documents for consideration during the appeal.

v. The record must be kept open for 15 calendar days to permit HealthPAC applicants and enrollees and their representatives to submit evidence and any other documents for consideration in the appeal after the hearing has concluded.

vi. HeathPAC applicants and enrollees and their representatives must be able to obtain reimbursement of HealthPAC enrollee's costs in order to attend an in-person hearing, i.e. transportation.

vii. Change in Process

a. At any point prior to or during a telephone or video conference hearing, at the request of either party or the decision maker, an in-person hearing can be ordered.

b. If an individual has an in person hearing scheduled, he or she may request a telephonic hearing 24 hours prior to the hearing date.

D. Timeframe for resolution of appeals and grievances

1. Standard disposition of grievances – Oral or written notice must be mailed within 60 calendar days of receipt of the grievance.

2. Standard resolution of appeals – HealthPAC must mail written notice within 45 calendar days of receipt of the appeal.

3. Expedited resolution of appeals – HealthPAC must mail written notice within 3 working days of receipt of the appeal. In addition, reasonable efforts to provide oral notice will be made.

4. Timeframes on the above may be extended by up to 14 calendar days if either the HealthPAC enrollee requests it, or the HealthPAC can show (to the satisfaction of the State DHCS upon its request) that there is a need for additional information and how the delay is in the HealthPAC enrollee's interest.

5. Written notice of the reason for the delay under (4.), above, must be provided, unless requested by the HealthPAC enrollee.

6. If a request for expedited resolution of an appeal is denied, the appeal must be treated under the standard resolution timeframe. In addition, reasonable efforts to give prompt oral notice of the denial must be made, and follow up with written notice within 2 calendar days must be provided.

E. Content of Notice of Appeals resolution

1. Written notice of the resolution must include:

a. The results of the resolution process and the date it was completed.

b. Be available in languages in addition to English as outlined in 42 C.F.R 438.10(c)

c. For appeals not resolved wholly in favor of the HealthPAC enrollee:

i. The right to request a State fair hearing and how to do so and the date by which the request of a State fair hearing must be made to be considered timely;

ii. If applicable, the right to request to receive benefits while the hearing is pending, and how to make the request; and

iii. That the HealthPAC enrollees may be held liable for the cost of those benefits if the hearing decision upholds the HealthPACs action.

F. State Fair Hearing

1. A State fair hearing may be requested within 90 calendar days of the date of the Notice of Resolution of the internal appeal of an action.

2. The State will take final administrative action in accord with 42 CFR 431.244(f)(1), or 431.244(f)(2), if applicable.

3. The HealthPAC will be a party to the State fair hearing.

G. Continuation of benefits during an appeal of action or a State fair hearing

1. The HealthPAC enrollee's benefits must be continued if:

a. A HealthPAC enrollee's eligibility is terminated or reduced;

b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c. The services were ordered by an authorized provider;

d. The original period covered by the original authorization has not expired;

e. The HealthPAC enrollees or provider (on behalf of the HealthPAC enrollees) timely files an appeal; and

f. The HealthPAC enrollee requests extension of benefits.

2. "Timely filing" as used in this section means filing on or before the later of either:

a. Ten (10) calendar days from the mailing of the notice of action

b. The intended effective date of the proposed action.

c. In the case of a State fair hearing, 10 calendar days from the date of the internal appeal decision.

3. Benefits that are continued under this section shall be continued until:

a. The HealthPAC enrollees withdraw the appeal;

b. Ten (10) calendar days pass after the mailing of a notice resolving the internal appeal adverse to the HealthPAC

enrollees, unless the HealthPAC enrollees requests a State fair hearing with continuation of benefits within 10 calendar days of the issuance of the internal appeal decision;

c. A State fair hearing decision adverse to the HealthPAC enrollees is issued,

d. As ordered by the Administrative Law Judge at the State fair hearing, in limited permissible circumstances, such as 431.230(a)(1); or

e. The time period or service limits of a previously authorized service has been met.

4. If the final resolution of the internal appeal or the state fair hearing is adverse to the HealthPAC enrollees, the HealthPAC may recover the cost of the services furnished to the HealthPAC enrollees while the appeal is pending, to the extent they were furnished solely because of the requirements of this section of the procedures.

5. If services were not furnished pending the internal appeal or the State fair hearing, and the resolution of the appeal reverses an action to deny, limit, or delay services, the HealthPAC must provide the disputed services promptly, and as expeditiously as the HealthPAC enrollee's health condition requires.

6. If the HealthPAC enrollee received disputed services while the internal appeal or the State fair hearing was pending, and the resolution reverses a denial of services, the HealthPAC must cover such services.

VI. LIHP Monitoring Reporting

CMS expects LIHP's to maintain a health information system that collects, analyzes and integrates the data necessary to implement the grievance and appeals process. To demonstrate the efficacy of the State's grievance and appeals process, the State Medicaid agency will provide to CMS the following data by LIHP program on a quarterly basis:

A. Time Period(s) Covered

B. Average Number of LIHP enrollees in the time period

C. Total number of appeal and the total number of grievance cases received by the LIHP and the State in the period;

D. Rate of Appeals and the rate of grievances per 1000 LIHP

E. Number and percent of cases resolved internally and through the fair hearing process, and outcomes of cases in the period inclusive of;

1. Number and percent decided in fully favor of the LIHP enrollee

2. Number and percent decided partially in favor of the LIHP enrollee

3. Number and percent not decided in favor of the LIHP enrollee

4. Number and percent withdrawn by the LIHP enrollee;

5. Number and percent of cases resolved through the fair hearing process, using telephonic procedures

    a. Number and percent decided in fully favor of the LIHP enrollee using telephonic procedures

    b. Number and percent decided partially in favor of the LIHP enrollee using telephonic procedures

    c. Number and percent not decided in favor of the LIHP enrollee using telephonic procedures

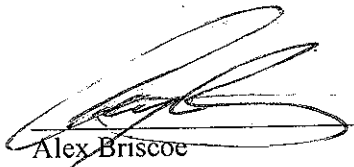
    d. Number and percent withdrawn by the LIHP enrollee using telephonic procedures;

F. Issues involved in all cases.

G. Time it takes to resolve the cases (upper and lower limits, median/mean)

    1. Number and percent of these cases involving expedited processing; and

H. Quality Improvement activities related to issues identified through the County's LIHP.

Signature  Date: 6/30/11

Alex Briscoe
Director, Alameda County Health Care Services Agency

HealthPAC
Health Program of Alameda County

Participant's Guide to the Grievance and Appeals Process

Complaints and Problems:

Your satisfaction is important to us! If you have a problem with HealthPAC, you have the right to make a complaint. This is also called filing an appeal or a grievance. An appeal is when you ask for review of an "action." Actions are:

- A denial, termination or reduction of eligibility for HealthPAC
- A denial or limited authorization of a requested service
- A reduction, suspension, or termination of a previously authorized service
- A failure to provide services in a timely manner
- A failure of HealthPAC or the State to act within the timeframes for grievances and appeals

Anything other than an appeal is usually called a grievance.

If you are successfully enrolled in the program, you will get a HealthPAC Participant Handbook and a HealthPAC ID card. If you apply for HealthPAC and are denied, you will be sent a notice. If you would like to appeal a denial, termination or reduction of eligibility for HealthPAC, or have a problem with your health care services or benefits, you can call **HealthPAC Customer Service: 1-877-879-9633**. We want to help you.

If you have a grievance or appeal, you may file it by phone or by filling out a grievance form. You can contact us at 1-877-879-9633. Callers who are deaf or hard of hearing may use the California Relay Service by dialing 7-1-1. You can also send a letter that describes your complaint to:

Fax: (510) 747-4522

or

Attn: HealthPAC Grievances & Appeals
Alameda County Health Care Services Agency
1000 San Leandro Blvd, Suite 300
San Leandro, CA 94577

You will be treated with respect during the HealthPAC grievance and appeal process. You have the right to give your views or propose a solution. You may speak for yourself or have someone else speak for you. You may ask to look at our records in connection with your grievance or appeal.

Timeframes:

If you are enrolled in HealthPAC, you will be mailed a notice at least 10 calendar days before a termination or reduction in service.

If you have a problem, you must file a grievance with HealthPAC within 60 calendar days of the event giving rise to the grievance. You must file an appeal of an action within 60 calendar days of the date of the Notice of Action.

HealthPAC Customer Service will review your grievance or appeal and send you a response within **45 calendar days**. If you think that waiting 45 days will harm your health, be sure to say why when you file your grievance. Then you might be able to get an answer within **3 working days**.

Continuation of Benefits:

If you submit an appeal or grievance, your benefits will continue until one of the following:

- You withdraw the appeal.
- Ten calendar days pass after a Notice of Resolution that denies your appeal is sent to you, unless you ask for a State Fair Hearing with continued benefits within **10 calendar days** of when the appeal decision is issued.
- A State Fair Hearing decision against your appeal is issued.
- The time period or service limit of a previously authorized service has been met.

State Fair Hearings:

If you are in HealthPAC, you may have a right to a State Fair Hearing. You can call HealthPAC Customer Service to find out whether your appeal can be brought to a State Fair Hearing.[1] If you have a right to a State Fair Hearing you may ask for a State Fair Hearing by filling out a form or calling **1-800-952-5253 (TDD users call 1-800-952-8349)**. You may also call HealthPAC Customer Service for help.

If you want a State Fair Hearing, you must ask for it within **90 calendar days** of the date of the Notice of Resolution of the appeal of an action.

LEGAL HELP: You may speak for yourself at the State Fair Hearing or have someone else speak for you, including a relative, friend or attorney. You must get the other person to help you. You may be able to get free legal help through Alameda County or legal services organizations. Check under "Legal Services" in the yellow pages.

[1] Only participants enrolling in the Low Income Health Program (HealthPAC MCE and HealthPAC HCCI) have a right to a State Fair Hearing. HealthPAC County enrollees do NOT have the right to a State Fair Hearing.

Appendix H:

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
Health Program of Alameda County (HealthPAC)

HealthPAC Statement of Income and Residency

I/We (1) _____,
(Print Full Name)

(2) _____,
(Print Full Name)

residing at _____,
(Street address) (City) (State) (Zip code)

declare under the penalty of perjury that the following information is true and correct to the best of my/our knowledge and belief:

_____ **I/We am/are currently unemployed and have no source of income.**

_____ **I/We am/are currently residing with a relative/friend who is providing free room and board.**

_____ **I/We am/are currently living off my/our savings account.**

_____ **I/We am/are currently a student receiving a student grant/loan.**

_____ **I/We receive free room and board in lieu of managing an apartment.**

_____ **Other (Specify)** _____.

_____ **I/We am/are currently receiving cash payment for work performed as follows:**

TYPE OF WORK:	***PAYMENT METHOD:***
_____ **Day Care Provider**	_____ **$** _____ **Daily**
_____ **Beauty Salon**	_____ **$** _____ **Weekly**
_____ **General Labor**	_____ **$** _____ **Bi-Weekly (every other week)**
_____ **House Cleaning**	_____ **$** _____ **Semi-Monthly (twice a month)**
_____ **Waiter/Waitress**	_____ **$** _____ **Monthly**
_____ **Other (Specify)** _____	_____ **$** _____ **Other (Specify)** _____

_____ _____
DATE *SIGNATURE*

Form No. 465-MI-15

APPENDIX I: HEALTH PROGRAM OF ALAMEDA COUNTY LIABILITY SCHEDULE

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY

ALAMEDA COUNTY MEDICAL CENTER/ COMMUNITY BASED ORGANIZATION

HEALTH PROGRAM OF ALAMEDA COUNTY (HealthPAC) LIABILITY SCHEDULE

EFFECTIVE, July 1, 2011

The total cost for a family in a year can NOT exceed 5 percent of the family's income.

% OF POVERTY LEVEL	HealthPAC CO-PAYMENT					***MAXIMUM GROSS MONTHLY INCOME PER FAMILY SIZE***										
	Emergency Co-Pay	Inpatient Co-Pay	Outpatient Co-Pay	Pharmacy Co-Pay[1]	Special Procedure[2] Co-Pay	1	2	3	4	5	6	7	8	9	10	FOR EACH ADD'L MEMBER ADD:
0-133%	0	0	0	0	0	1207	1630	2054	2477	2901	3324	3747	4171	4594	5017	423
133 - 150%	0	75	0	3	75	1361	1839	2316	2794	3271	3749	4226	4704	5181	5659	478
150 - 200%	0	125	0	3	125	1815	2452	3088	3725	4362	4998	5635	6272	6908	7545	637
Over 200%	PATIENTS WHOSE GROSS MONTHLY INCOME IS OVER 200% OF THE FEDERAL POVERTY INCOME GUIDELINES SHALL BE CONSIDERED PRIVATE PAY.															

[1] Pharmacy charge $3 per prescription drug with $36 per visit maximum.

[2] Examples of special procedures include:

- bronchoscopy
- cat scans
- cholecystectomy
- EKG
- EMG (electromyography)
- endoscopy
- holter monitor
- hysteroscopy
- implantation of pumps
- pacemakers
- stimulators or other devices
- IV infusion/chemotherapy (co-pay to cover duration of treatment plan)
- laparoscopy
- MRI (Magnetic Resonance Imaging)
- myelography
- nuclear med
- thoracoscopy
- venous/arterial catheter placement

HealthPAC
Health Program of Alameda County

Quality Measurement and Improvement Plan

QUALITY IMPROVEMENT PROGRAM GOALS AND SCOPE

The purpose of the HealthPAC Quality Improvement (QI) Program, overseen by the Alameda County Health Care Services Agency (HCSA), is to objectively monitor and evaluate the quality, appropriateness, and outcome of care and services delivered to members of HealthPAC. The QI Program is structured to continuously pursue opportunities for improvement and problem resolution. Settings and types of care to examine are selected based on volume, opportunities for improvement, risk, and evidence of disparities.

The QI program is designed to ensure that:

- High quality, safe, and appropriate care that meets professionally recognized standards of practice is delivered to all enrollees.
- The plan promotes objective and systematic measurement, monitoring, and evaluation of services and implements quality improvement activities based upon the findings.
- Activities to improve processes by which care and services are delivered are developed, implemented, evaluated and reassessed.
- Quality of care problems are identified and corrected for all provider entities.
- Physicians and other appropriate licensed professionals are an integral part of the QI program.
- Appropriate care consistent with professionally recognized standards of practice is not withheld or delayed for any reason, such as potential financial gain or incentive to plan providers.
- The plan does not pressure institutions to grant privileges to health care providers that would not otherwise be granted.
- The plan does not pressure health care providers or institutions to render care beyond the scope of their training or experience.

The scope of the QI Program is comprehensive and encompasses major aspects of care and service in the HeathPAC delivery system, and the clinical/non-clinical issues that affect its membership. These include:

- Availability and access to care, clinical services, and care management.
- Cultural and linguistic issues
- Special needs populations such as persons with chronic conditions, homeless individuals, individuals with serious mental illness, the re-entry population, and others.
- Patient safety

- Member and Provider satisfaction
- Member and Provider education
- Continuity and coordination of care
- Utilization trends including over- and under-utilization
- Clinical practice guideline development, compliance, and revision
- Acute, chronic, and preventive care services for adults
- Primary, specialty, emergency, inpatient, and ancillary care services
- Case review of suspected instances of poor quality
- Credentialing and recredentialing activities

ORGANIZATIONAL STRUCTURE AND RESPONSIBILITY

Overview

HCSA is responsible for oversight of the QI program. The program will utilize and build upon existing quality assurance and improvement structures and activities already taking place among members of the Alameda County Safety Net Council. In addition, HCSA contracts with the Alameda Alliance for Health (Alliance) to perform certain quality management functions as articulated later in this document.

Alameda County Health Care Services Safety Net Council

The Safety Net Council is comprised of Health Care Services Agency leadership (director, finance director, HealthPAC administrator, Public Health Director, Public Health Officer, Behavioral Health Care Services Director and Medical Director); the Alameda Alliance for Health leadership (Chief Executive Officer, Medical Officer); ACMC leadership (Chief Executive Officer, Chief Strategy & Integration Officer, Chief Financial Officer); all HealthPAC clinic Chief Executive Officers; the Alameda Health Consortium Executive Director.

The Safety Net Council and its members provide executive level input and oversight into the HealthPAC Quality Improvement (QI) Program; however, the HCSA director is ultimately responsible for making decisions about the program. The Safety Net Council duties include:

- Annually review, update and approve the Quality Improvement Program description, defining the scope, objectives, activities, and structure of the program.
- Review annual QI report and evaluation of QI studies, activities, and data on utilization and quality of services.
- Assess QI program's effectiveness and direct modification of operations as indicated.
- Provide oversight and guidance of the work of the Clinical Quality Improvement Workgroup.
- Designate a member of senior management within their organizations that has the authority and responsibility for the overall operation of the quality improvement program within their organization.

HealthPAC Clinical Implementation Workgroup (CIWG)

The Clinical Implementation Workgroup is responsible for the development, implementation, oversight, and monitoring of quality improvement activities within HealthPAC with a focus on priority areas as identified by the Safety Net Council. This workgroup meets at least quarterly , and as often as needed, to follow-up on findings and required actions. This group includes key administrative and clinical staff members that represent the range of providers.

CIWG responsibilities include:

- Approve selection, design, and schedule for studies and improvement activities.
- Designs standards of care such as panel management standards, care management standards, and other best practice models.
- Review results of established quality measures, annual site visit assessments, and improvement and intervention activities.
- Provides on-going reporting to the Safety Net Council.
- Meets at least quarterly and maintains minutes of all committee meetings.
- Review member grievance and appeals information.
- Review utilization management results.
- Provides guidance to staff on quality management priorities and projects.
- Monitors progress in meeting quality improvement goals.
- Annually evaluates the effectiveness of the Quality Improvement Program.
- Review and approve QI policy and procedure revisions, and annual QI Program description, work plan, and evaluation.

HealthPAC Contract with the Alameda Alliance for Health

The County delegates responsibility for aspects of the Quality Improvement Program. The Alliance will perform the following quality measurement and monitoring functions for the HealthPAC program:

- Provide a representative to the CIWG,
- Credential participating providers,
- Quarterly reports on HEDIS-like quality measures,
- Provide ad-hoc quality reports as requested by HCSA and/or the CIWG,
- Provide reports on utilization trends, and
- Report on the number of grievances and appeals received, upheld and overturned.

Alameda County Behavioral Health Care Services

The Behavioral Health Care Services (BHCS) department of HCSA participates in the aforementioned groups with designated staff members and provides additional quality improvement data and support to the HealthPAC QI effort. BHCS performs the following functions:

- Ensure appropriate credentialing of specialty mental health participating providers;
- Quarterly reports on mutually identified measures;

- Provide ad-hoc quality reports as requested by HCSA and/or the QI,
- Provide reports on utilization trends, and
- Report on the number of grievances and appeals received, upheld and overturned

Alameda County Public Health Medical Officer

The Alameda County Public Health Medical Officer is a physician who is responsible for, and oversees the Quality Improvement Program. The Medical Officer provides leadership to the Quality Improvement Program through oversight of QI study design, development, and implementation. The Medical Officer makes periodic reports of committee activities, QI study and activity results, and the annual program evaluation to the Safety Net Council.

HealthPAC Quality Coordinator

The HealthPAC Quality Coordinator is a nurse and HCSA employee who coordinates the HealthPAC Quality Improvement Program. The HealthPAC Quality Coordinator conducts site visits, does assessments, collects data and presents information to the QI Workgroup. The HealthPAC Quality Coordinator works with the Workgroup to identify training needs at service delivery sites and provides hands on training to staff.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All employees, contracted providers, and sub-contractors of the HealthPAC maintain the confidentiality of personally identifiable health information, medical records, peer review, internal and external, and internal electronic transmissions and quality improvement records. They will ensure that these records and information are not improperly disclosed, lost, altered, tampered with, destroyed, or misused in any manner. All information used in QI activities is maintained as confidential in compliance with applicable federal and state laws and regulations.

Access to member or provider-specific peer review and other QI information is restricted to individuals and/or committees responsible for these activities. Outside parties asking for information about QI activities must submit a written request to the Medical Officer. Release of all information will be in accordance with state and federal laws.

Committee members may not participate in the review of any case in which they have a direct professional, financial, or personal interest. It is each committee member's obligation to declare actual or potential conflicts of interest.

All QI meeting material and minutes are marked with the statement "Confidential". Copies of QI meeting documents and other QI data are maintained separately and secured to ensure strict confidentiality.

METHODS AND PROCESSES FOR QUALITY IMPROVEMENT

The Quality Improvement Program employs a systematic method for identifying opportunities for improvement and evaluating the results of interventions. All program activities are documented in writing and all quality studies are performed on any service or product for which it seems relevant.

Identification of Important Aspects of Care

HealthPAC uses several methods to identify aspects of care that are the focus of QI activities. Some studies are initiated based on performance measured as part of contractual requirements and member demographics, utilization patterns, and risk areas. Other studies are initiated based on analyses of the assessments performed during site visits. Population based information captured by the Public Health Department is also used to set priorities.

Data Sources

Data sources include, but are not limited, to the following:

- Claim and encounter submissions.
- Disease registry information.
- Credentialing, medical record review, and audit findings.
- Member and provider grievance and appeal data.
- Potential Quality Issue tracking/trending data.
- Other clinical or administrative data.
- Public health department population data.

Data Collection, Analysis, and Reporting

HealthPAC has the capability to design sound studies of clinical and service quality that produce meaningful data. Data collection and coordination activities are performed primarily through the Clinical Implementation Workgroup.

ACTIONS TAKEN AS RESULT OF QUALITY IMPROVEMENT ACTIVITIES

Action plans are developed and implemented when problems or opportunities for improvement are identified. Each corrective action plan specifies who or what is expected to change, the person responsible for implementing the change, the appropriate action, and when the action is to take place. Actions will be prioritized according to possible impact on the member or provider in terms of urgency and severity.

TYPES OF QI MEASURES AND ACTIVITIES

HEDIS-LIKE Measures

A subset of HEDIS- like (Health Effectiveness Data Information Set) as agreed upon by the CIWG are calculated and reported annually. Additional quality measures as defined by the HealthPAC implementation workgroup are also assessed and reported on annually.

Annual Site Assessments

The HealthPAC Quality Coordinator conducts annual site visits to all medical homes for HealthPAC. During the site visits the Coordinator conducts assessments of the clinics progress in meeting panel management and care management standards. From the assessment, the Coordinator develops a HealthPAC report summarizing the findings. From the findings the Clinical Implementation Workgroup develops a training plan.

Trainings

The HealthPAC Quality Coordinator and designated staff from behavioral health care services organize trainings each year that all of the providers in the network can participate in. At least four trainings are offered each year. The content of the trainings is developed based on the findings in the site visit assessments and with input from the CIWG. In addition, the HealthPAC Quality Coordinator provides site based trainings as needed.

Patient Safety and Quality of Care

The HealthPAC QI process incorporates several mechanisms to review incidents that pose potential risk or safety concerns for plan members. Quality of care and patient safety are monitored through review of the following:

- Complaint and grievance processes.
- Iatrogenic events reported on claims and encounter submissions.
- Concurrent review of inpatient admissions.
- Investigation of reported and/or identified potential quality of care issues.
- Credentialing and re-credentialing review of malpractice, license suspension registries, loss of hospital privileges.

Access and Availability

The QI Program monitors access and availability of care including member wait times and access to providers for routine, urgent, emergent, and preventive, specialty, and after-hour care. Access to health care is ensured by monitoring compliance with wait time standards for provider office appointments, telephone calls, and appointment availability. HCSA (including public health and behavioral health) and Alliance staff review the member complaints about access and make recommendations for intervention. The CIWG provides input into the recommendations and how to implement changes.

Disease Management and Practice Guidelines

Healthcare homes maintain responsibility for basic case management, including preventive health care and disease management. The QI Program includes a process to develop and/or adopt and update clinical practice guidelines that assist providers in the delivery of preventive, acute, and chronic care, and disease management. Approved guidelines are consistent with standards and recommendations of professional organizations, and/or scientific evidence, clinical trials, validated studies, or published reports

COMMUNICATION

The County's contracts with its providers foster open communication and cooperation with QI activities. Contract language specifically addresses:

- Provider cooperation with QI activities.
- Plan access to provider medical records to the extent permitted by state and federal law.
- Provider maintenance of medical record confidentiality.

- Open provider-patient communication about treatment alternatives for medically necessary or appropriate care.

Provider involvement in the QI program occurs through membership in standing and ad-hoc committees, and attendance at CIWG and Safety Net Council meetings. Providers and members may request copies of the QI program description, work plan, and annual evaluation. Provider participation is essential to the success of QI studies and those that focus on improving aspects of member care. Additionally, provider feedback on surveys and questionnaires is encouraged as a means of continuously improving the QI Program.

EVALUATION OF QUALITY IMPROVEMENT PROGRAM

The QIWG reviews a written evaluation of the overall effectiveness of the Quality Improvement program on an annual basis. The evaluation includes, at a minimum:

- Changes in staffing, reorganization, structure, or scope of the program during the year.
- Resources allocated to support the program.
- Comparison of results with goals and targets.
- Tracking and trending of key indicators.
- Description of completed and on-going QI activities.
- Analysis of the overall effectiveness of the program, including assessment of barriers or limitations.
- Recommendations for goals, targets, activities, or priorities in subsequent Quality Improvement Work Plan

The review and revision of the program may be conducted more frequently as deemed appropriate by the QIWG, Medical Officer, Director of Health Care Services Agency, or Safety Net Council. The CIWG's recommendations for revision are incorporated into the Quality Improvement Program description, as appropriate, which is reviewed by the Safety Net Council and submitted to DHCS on an annual basis.

ANNUAL WORK PLAN

A Quality Improvement Work Plan is received and approved annually by the Safety Net Council. The work plan describes the quality management goals and objectives, planned projects, and activities for the year, including continued follow-up on previously identified quality issues, and a mechanism for adding new activities to the plan as the need is identified. The work plan delineates the responsible party and the time frame in which planned activities will be implemented.

QI DOCUMENTS

In addition to this program description, the annual evaluation and work plan, other additional documents important in communicating QI policies and procedures are:

- The contracts provide detail about the expectations of each partners roles and responsibilities.
- The "HealthPAC Plan" provides information about eligibility, scope of services, and general responsibilities of each partner.

- The "HealthPAC operations manual" documents policies and procedures under the Alameda County HealthPAC.
- Monthly e-mail blasts to the HealthPAC providers will give program updates.

These documents, or summaries of the documents, are available upon request to providers, members, and community partners.